

DEVELOPMENT OF THE FAMILY SYSTEM-THERAPEUTIC APPROACH IN THE ADDICTIONS TREATMENT IN SERBIA

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ABSTRACT

The roots of system-group family therapy in alcoholism, from which the Belgrade School, originated in the socio-psychiatric paradigm (medical model of addiction, psychodynamic orientation and socialization of psychiatry), Led by these socio-psychiatric paradigm was in 1963. formed the Institute for Mental Health and on the same day formed Socio-Therapeutic-Club of treated alcoholics. Involvement of addict's wife and other family members, and later the professional environment in treatment began in the late 1970s, when *The Day Hospital for Family Alcohol Therapy* (1978) has been formed. A general system theory was introduced very consistently into this therapeutic model, which included emphasizing the psychoeducation of the identified patient and family members as well as the formation of therapeutic groups of multiple families as a form of prolonged treatment (stabilization phase), while, in the same time, preserving the concept of the therapeutic community and socio-therapeutic clubs as a form of prolonged treatment or recovery. The basis of the family-system therapy concept of the "Belgrade School of Addictology" is related to understanding the process of systemic equilibrium, through the processes of morphogenesis and homeostasis, namely through the understanding of pathological aspects of homeostasis called "processes of adjustment of the alcoholic family or system". Eco-system processes significantly determine the characteristics of individuals, families, social institutions, as well as the characteristics of health and specificity of the disease. With that on mind, it is necessary to understand the transformation of therapeutic models that obviously cannot be purely medical, not as purely psychiatric. It has to be understood as a variable and individualized living processes.

KEY WORDS

addiction, systems theory, family therapy

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INTRODUCTION

The development of medical alcoholology in Serbia began in the 1950s and is related to the treatment of patients with alcoholic psychosis, alcoholic encephalopathy and neurological damage produced by excessive alcohol consumption – mainly at the departments of psychiatric hospitals (Belgrade, Kovin, Gornja Toponica). Treatment was therefore strictly medical and exclusively hospital oriented. At the start of the 1960s, at the Neuropsychiatric Clinic in Belgrade the first dispenser for alcoholism treatment has been formed. The first Club of Treated Alcoholics at the Department for mental Health has been formed in 1963¹.

All of that, in its specific way started the deconstruction of moral approach to alcoholism and other mental disorders. That has been achieved with focusing more on the methods of daily hospital care rather the classical medicinal model of psychiatry – which has been enabled with the inclusion of community in the process of addicts or mental patient rehabilitation. With the financial support of the welfare state the image of mental institutions has been changed with regard to the mental disorder treatment. With the better image, came the better results of rehabilitation. In addition to that improvement, in 1975, the first Clubs of Treated Alcoholics has been formed in Serbia. Clubs have strengthened the social psychiatry approach and movement – particularly in the alcoholism treatment. The state financial resources allocated to the social psychiatry movement for that time has been satisfying and has been raised frequently. Even with the implementation of half-hospital oriented and outer-hospital treatment, process of rehabilitation mostly began with the alcoholic's admission in the hospital – with the episodic character of addict, because the most common hospital treatment process has been solved with the dismissal after the episode. It all involved the medical model of addiction treatment, which survived through the 2nd half of XX century thanks to the pharmaceutical industry. The strength of the medical model have proven itself harmful, because of the retrograde tendencies in the therapy plan predominantly based on medicalization, shutting down the social psychiatry program, and poor involvement of the welfare state. It has been only in the past three decades realized that there is a need for a new approach and innovations in the process of treatment in which the experts and academic community of different professions should be involved [1].

A critical review of the application of the traditional models of treatment of alcohol and other drugs have yielded changes [2-7]. The treatment approaches have moved away from the old approach to abstinence as a key mission and necessary precondition for the beginning of treatment. Contemporary tendencies are giving up from treating the abstinence as the only condition to stop the damage and disorder and insist on abstinence as the precondition for treatment in medical model allowing for an increase in the approaches which claim that abstinence is not necessary nor it is a goal of the treatment. The more popular are the programs of *harm reduction* and *substitution programs*. That kind of approach has shaken the traditional social psychiatry foundations of addiction treatment. Today, this development of events seems to be immanent considering the little number of the successful treatments conducted by the traditional model.

Already in 1970s system theory in psychology and psychiatry critically challenged the traditional approach primarily by lighting up the humane approach to interaction – the focus has been to improve the interaction of the family with the addict member. Systemic understanding of family interactions has inaugurated the revolutionary concept of identified patient (IP), a different concept, or new paradigm of symptom creation. This triggers the development of a then new and now powerful psychotherapy modality – systemic family therapy.

From the standpoint of general system theory alcoholism and other addictions, as well as other psychosocial phenomena and mental health disorders, are not understood as disorders that determine only the characteristics and events of the individual. Addictions have been seen as a product of systemic interaction disorders and their maintenance is possible because of the pathological stability of the system in which they occurred. In this way, the attachment is maintained in the system and supports the system and its pathological stability [8].

System theory recognizes addictions as a prototype of interacting diseases. This interaction component of addiction as a symptom in the family and in the wider systems is directly related, above all, to the vital emotional attributes of interactions and relationships in the family. Also important are the interactions of individuals with out-of-family groups which are emotionally colored and highly relevant to the processes of learning, developing, and maintaining addiction. The systematic approach to addiction insists on the process of pathological equilibrium between the system at individual level and processes in the family and/or social group. The processes of creating each addictive disease cannot be detached from the wholeness of family interactions and viewed as isolated “whirlpool of alcoholics” or “drug addicts” – in other words, as a special mysterious process that arises only from drinking, “drugging”, “gambling”. On the contrary, these systemic processes can be clearly found in current events in the family. It is necessary to observe the whole, and these processes are sought through understanding the whole, not by analyzing the states and characteristics of individuals, because, in fact, only holistically we can understand how some traits are formed, how disturbed relationships are maintained, and finally how they are transmitted to some members in the next generation while some of them are not passed on. The origin and the course of their formation can be seen through the analysis of the three-generation or multi-generation “emotional field” of the family.

In this way, consumption of alcoholic beverages is emphasized as a widespread and lasting phenomenon in social systems, with the characteristics of “symptoms in the system”. Namely, addictive behaviors, including drinking alcohol in most societies and cultures are socially acceptable, expected and desirable, present for “thousands of years”, so we can talk about social-psychological phenomena with elements of the “natural process” present in every part of the World and in extremely different social and psychological circumstances and contexts. It means that any social phenomenon that lasts and survives in natural human systems, inevitably changes the natural characteristics of the participants, so that all addictive behaviors and addictive diseases as long-present pathological behavioral patterns and phenomena with elements of social pathology must be considered as one of such influential processes, influential to the extent that they very seriously alter the natural characteristics of individuals, families, narrower and wider social communities and institutions, as well as social and political systems [6-7].

It can be said with certainty that in the European territories the phenomenon of drinking alcohol as a “symptom of the system” reflects the systemic features of that wide area. Namely, one can notice the regulatory structure of the system (rules, norms, rituals, beliefs related to drinking and intoxication as social behavior) and elements of the process of creating addiction and “progression” of the disorder (predictable course, stages and crises). According to the systemic model of alcoholism, as well as of other addictions and their maintenance as “symptoms of the system”, all elements of the system are involved all the time (individuals, families, states, cultural characteristics) through the mutual relations by which the systemic equilibrium takes place. Obviously, this understanding of the onset of addiction is not about one cause, but about the many possible causes of addiction, so – by systemic theorists – the outcomes of the addiction process are very diverse no matter what is considered the cause or causes [1].

This is the systemic concept of circular causality. It indicates that individuals, through their behavior within the whole family system and every other social system, shape each other, so that the behavior of any member influences the behavior of other members of the system. It is equally important to understand the circularity in family interaction processes and the emotions within them, as well as to understand the meaning of homeostasis or the so-called adjustment process in the present system.

It is important to recognize circular causality in the creation of addictive diseases in the individual. Even when applying the medical model, it is clear that addiction develops as a neurobiochemical continuum that has quite predictable stages and symptoms, with abstinence syndrome symptoms appearing as a trigger for process circularity and for maintaining addictive behaviour and thinking in all individual's relationships with the family and the social environment.

Therefore, the development of addiction - within the individual and the family system - through circularity and homeostatic processes, provides a continuum in the formation and duration. These addictions give the characteristics to specific and diverse processes, events and symptoms of the outcome. Forward and backward shifts are also possible. Stopping the flow in this continuous process of development is possible only by stopping the process of pathological homeostasis or adaptation. Some elements of these processes can be identified in the addict, but many exist outside the addict-individual – in the system itself.

It follows that each family has its own addiction, because the processes of creating each addiction cannot be torn from the integrity of family interactions and considered only as some isolated special “mysterious” (neurobiochemical) process in the individual. It can also be said that each social or state community has its own addiction. These views inaugurated the application of systemic family therapy in the treatment of addiction diseases at the *Belgrade School of Addictology*.

Everywhere in the World, the need to treat addiction is enormously high. The treatments implemented, unfortunately, are rare which also indicates strong homeostatic processes in almost all Western societies for the creation and duration of all addiction diseases until definitive damage is created.

To put into the consideration everything written so far about drinking alcohol and the existence of well-developed social psychiatry in the former Yugoslavia, it is quite expected that the beginnings of the application of system theory and family therapy in the field of addictology in Serbia began in the treatment of alcoholism. This has also happened at the Institute for Mental Health (IMH) and is tied to the name of Branko Gačić and the initiation of the first changes in the traditional treatment of alcoholism. In 1973, he and a group of junior associates formed the first treatment group within the IMH Day Hospital at which he began to include alcohol addict's wives in the treatment of their husbands, after completing an episode of hospital treatment. Soon, in his first book in 1978 [1; pp.3-4], he called this form of treatment for alcoholics “Intensive Combined Family Alcohol Therapy” (ICFAT). With the classic and traditional medical parts of the program being referred to as symptomatic therapy and family therapy, orientation to marital and family problems has the significance for etiological therapy [9-11].

In 1978, the Center for Family Therapy of Alcoholism (CFTA) was established, headed by Branko Gačić, which gave additional impulses not only to the family therapy of alcoholism, but also to the further development of family therapy in Serbia. Namely, the first generation of educated family therapists in Serbia soon came of age, completing sub specialization in systemic family therapy, under the programs of the Institute for Family Therapy and Tavistock Clinic, London (1984-1988). Through practical work and educational activities at the Center

for Family Therapy of Alcoholism, the involvement of family members in the treatment of their alcoholics, became a more widely used therapeutic practice in other institutions (Nis, Skopje, Sombor, Zrenjanin, Novi Sad, Belgrade and other cities). Gačić then conducted another complete study of the evaluation of family alcohol therapy for the period 1986-1989 on 1989 married couples and successful access was reaffirmed [11]. This therapeutic approach, which in his 1992 work [5-6] Gačić described as a Belgrade systemic Approach to the Treatment of Alcoholism, was enriched by significantly greater involvement of other social systems in the treatment of alcoholism, and thus became increasingly feature of the so-called network therapies, or in more modern language ecosystem therapies. However, it is essentially a model that can be called Systemic Group Family Alcohol Therapy (SGFAT) [6; pp.12-13]. Over the years, this approach – primarily at the Institute of Mental Health – has been used in the treatment of opiate addiction and other psychoactive substances related addictions, and recently in the treatment of pathological gambling and addiction to video games and the Internet. All these developments allowed for the term “Belgrade School of Addictology”. The chronology of Belgrade School of Addictology is shown in Table 1.

Table 1. Chronology of Belgrade School of Addictology development.

1963	Sociotherapy Club for Acoholics Treatment (SCAT)	
1963-1973	A Department of IMH Day Hospital:	Socio-therapeutic group work with alcoholics is applied
1973-1978	Day Hospital for Family Alcohol Therapy	Intensive Combined Family Alcohol Therapy” (ICFAT) <ul style="list-style-type: none">• Medical parts of the program (symptomatic therapy)• Wife involvement and orientation to family relationship (etiological therapy)
1978 to the present	Center for Family Therapy of Alcoholism	Belgrade systemic Approach to the Treatment of Alcoholism <ul style="list-style-type: none">• Significantly greater involvement of more family members and the professional environment
1993	Clinical Department for the Treatment of Addiction Diseases	Hospital phase of systemic group family therapy for addiction diseases
2001	Addiction Disease Clinic Clinical Department for the Treatment of Addiction Diseases Day hospital with two treatment groups and CTA (Systemic Therapy of Clubs of Treated Alcoholics) Center for Family Therapy of Alcoholism - Two Therapy Groups + Family CTA (Clubs of Treated Alcoholics) Adolescent Day Family Hospital Day Care	Systemic Group Family Addiction Therapy (SGFAT)

BASIC THERAPEUTIC PRINCIPLES OF “BELGRADE SCHOOL OF ADDICTOLOGY”

Elements of the medical model are still used in the Belgrade School. The beginning of treatment has the features of traditional medical diagnosis and can be considered as “making a medical diagnosis more broadly”. It is conducted in an active manner according to the principle of “mosaic building” with the aim to, besides medical diagnosis, assess social and family consequences and to continue the motivation of the addict to initiate some of the existing forms of therapeutic or at least counselling interventions. Therefore, in addition to the classic medical examination and psychiatric examination, it is necessary to take into account the interaction or, in other words, family-systemic aspect of the problem in this process.

The next “diagnostic level” is the family-system level of completing the assessment and diagnosis. However, there are several important facts to keep in mind when starting and applying family therapy, such as:

- diversity of clinical images of addiction,
- comorbidity of alcoholism and other additions,
- significant psycho-organic impairment of the addict,
- personality disorders, sociopathic and criminal behaviours,
- permanent bodily harm to addicts.

The family-systemic level of assessment is conducted through a specific diagnostic and motivational procedure throughout and during the so-called bifocal effects on the patient and family. That involves the simultaneous implementation of diagnostic procedures and therapeutic-motivational interventions.

The specificity of this sub-phase relates to the planned and successive involvement of family members and other individuals in the social system. So this is a diagnostic/motivational and mild to moderately confrontational process that is focused on the addict but also the process which gradually also targets the family as a whole. This is necessary in order to obtain valid heteroanamestic data, and above all, to continue motivating or further deepening the data on drinking and the consequences of drinking, thereby achieving therapeutic “pressures”, “crises” or “breaking” of the system around the addict. Through the mentioned process, the addiction is successfully controlled and maintained by the addict during the long period of time.

The specificity of family-system diagnostics is the “first family interview” which has elements of a systemic or conjoint session. When done well, it is considered a powerful tool for diagnosing family disorders and ending the motivational process. The therapist conducts an interview with all family members, assessing both verbal and non-verbal communication (sitting schedule, body posture, tension, affective expressiveness, relationship characteristics, who holds control over communications, who most interrupts other members, who with whom mostly communicates, etc). This targeted interview with a dependent member and his or her family members usually takes place after a medical and psychiatric problem identification procedure, i.e., after a number of motivational interviews or screening. It can be performed at a specialist addiction treatment facility, a social work centre, a specialized counselling centre, or very rarely at a GP. Once the diagnostic process is started, it should proceed continuously until the next appointment and some appropriate treatment is agreed and accepted. Sometimes it takes place as a one on one intervention and sometimes as a series or sequence of interventions in one or more institutions. The final diagnosis must be the integration of all the data collected and the “creation of a diagnostic mosaic” [13-14].

A key part of the Family Addiction Therapy Program according to the concept of “Belgrade School” takes place in the conditions of daily hospital treatment. This means that the patient

and the family spend one part of the day in intensive group-therapy work within the therapeutic groups of multiple families, and spend the other part of the therapy day at their home. The therapeutic action is directed to the family as a therapeutic unit, and at certain points in the program, to the social and professional environment as a whole system. This implies for all participants in the treatment the position of an integral part of the patient's addictive system, i.e. for all participants it means taking the position of co-patient contributing to homeostatic processes, the outcome of which is the duration of addiction.

Serious psychoeducation of the patient and the family is necessary in order to qualify their participation in maintaining the dysfunctional system and to achieve the necessary changes in family functioning.

An important feature is the existence of successive phases in the implementation of programs. On the one hand this emphasizes the levels of therapeutic requirements and achieved or unrealized achievements, and, on the other, it determines the order of analysing the dimension of time. Dimension of time looks like this: first, the present is made and then the past is considered. Eventually plans for the future also can be considered. Then it is insisted on specification - individualization of programs for each family through combining techniques and methods of family therapy and group psychotherapy, and through the possibilities of implementing programs at each level of clinical work: clinical ward, day care, hospital, outpatient family groups, club and dispensary depending on patient status and family progression during the therapy program. This program is phased in as group family therapy for multiple families. The groups are of medium size, i.e., 6-8 families. Groups can be structured as groups of married couples with the possibility of involving other family members as well as members of the professional or wider social system (network therapy); groups combined of married couples and single individuals (divorced, widowed) but having a complete family; groups of young alcohol addicts (18 to 25 years old); alcohol addicts' family groups. This is intensive phase of treatment or phase of family reorganization, in which new initial functions without alcohol are established (structural and functional reorganization of the family system from "wet" to "dry" system). During the intensive treatment phase at the day hospital, the therapy protocol insists on the daily presence of families. A necessary therapeutic minimum is the presence of an identified patient and at least one family member. The day-hospital therapy program lasts about 3-4 hours. Namely, direct group therapy work lasts 3 hours (twice for 90 minutes each). Families spend the rest of their day in a day hospital in so-called home activities, socialization and recreational activities. The family is there to help plan, organize, and accomplish their alcohol-free lives.

The daily life of the family (daily routines, communication, daily plan realization) during the intensive phase of treatment is analysed and corrected through a continuous group procedure called "actualities". In parallel with the "actualities" there is a psycho-educational process for the patient and the family – about alcoholism, its occurrence and maintenance in the family as a system and about the consequences in all areas of functioning. The aim of this psycho-education is not only to acquire knowledge and successfully pass the exam, but also to recognize one's "case" in theoretical settings, which is the main criterion for assessing the degree of completion of this task. In this way, participants obtain a "qualification" for further treatment, that is, for a favourable and "reasonable" view of the past. Thus, this process is also characterized by intense joint learning of the theory of alcoholism and the family. Given that the couple is tasked with learning together from one material ("from one book"), such a way of learning and taking the exam together is one of the therapeutic techniques which tests the intrinsic motivation of the couple/family but also restores broken communications and disturbed community of the couple or family. The exam is taken as a classic exam in front of a group which, together with the therapist, assesses the result of the exam. It is assessed

whether the family has passed, therefore, individual achievement is not valued, but both success and failure are common products.

After passing the exam, approximately three weeks after joining the group, the married couple, with older children (over 12 years of age) and significant persons from the family and social network (usually 5-10 people), have a so-called “Big show”. “Big presentation” is a therapeutic task that seeks to make the patient and family look at the facts of the past in a new way, based on the acquired theoretical knowledge and knowledge about the systemic model of family dependency. Great representation carries the therapeutic elements of self-discovery – insight and discovery before others. This insight is not psychoanalytically conceptualized, but represents an awareness and understanding of the process of the emergence and intensification of alcohol addiction and the consequences that have taken place in the family. This insight has the meaning of moral inventory².

The grand presentation has the form of presenting an autobiography, but very self-critically connoted, with the aim of “soberly perceiving the drunken/addictive self, and of dry system seeing the pre-existing wet system”. It only somewhat carries elements of insight in a psychodynamic sense, since one of the tasks within the great representation is to look at one’s own development and relationships with the primary family and key persons within it, but through understanding the family as a whole system – “family as a whole” (in the time dimension of the system model of the family). This part is the most complex and is largely conditioned by the quality of group dynamics and the knowledge and skill of the therapist. It is the hardest feasible due to the existence of rigid defence mechanisms – such as mutual projection, negation, minimization, but also emotional attributes from “coalitions”, “fatigue” “and” *contracts* “or” *pacts* among family members, especially partners, because of the massive manipulations and strategies of alcoholics to maintain control and power in the system, sometimes making it difficult to differentiate manipulations from psycho-organic impairments, i.e. cognitive deficits and permanent personality disorders in both the patient and family members.

So, there may be resistance to looking at the past by every family member, and even the entire family system, (not just addicts) in order to maintain homeostasis, or more precisely, “pathological balance” or “pathological gain” from alcoholism. The “big presentation” is prepared by all family members participating in the treatment. They talk about the past, look at their behaviours, think and write down their newly discovered views and form a written text, which is a kind of “novel” or “public recognition”.

An unsuccessful grand presentation cannot actually exist. Difficulties in perceiving family alcoholism are in fact the reason for additional work with the family. Work on the “big presentation supplement” takes place with a therapist or group, and sometimes requires a so-called a team intervention or the help of older group members. The “supplement” is done in front of the group. Key resistances may stem from “pacts” and “coalitions” in the family, so a change in the form of treatment may be needed. Therefore, a large representation is a key “crossroads” in the therapeutic process. The therapeutic goal of great representation is successful if, through the exposure of the addicts and other family members as a whole, an “insight” is achieved that should be accompanied by a milder or more intense emotional experience similar to catharsis. Thus, it is expected to “see” the whole system through the emotional expression of the members of the system, verbally redefining dysfunctional communications, irrational emotions and erroneous role-playing, inversion of positions and interpersonal relationships. Success and failure can be viewed through the fact that each person spoke of himself/herself and his/her behaviour, his/her responsibility for the outcomes and consequences for the family, not about the others, without explaining his/her behaviour according to the other’s feelings and behaviour. For an alcoholic, this is difficult because of

the massive deposits it has formed through social comparisons, negations, and tactics of “keeping” addiction symptoms, but also because of a disturbed value system, disturbed behaviour patterns, and psycho-organic disorders. However, this is difficult for alcoholic, mainly because of the fear of losing position in the “playful scheme”, which also loses the key support that provides that person with a sense of dominant relationship with the object. For other members of the family, especially for the wife of the addict, the difficulties are the same, because she is also a person with a high degree of dependence on her husband. Her defence mechanisms are similar and integrated into the marital relationship. In addition, it is difficult to relinquish the “gain from alcoholism” (or other addiction) and from a high degree of control in relation to the addict or to the system he or she has exercised during the addiction of her husband or other family member. It is especially difficult for her to remove the “culprit label” from the addict. Successful realization of insight, through successful “big representation”, creates relief of tension in the family system, but also represents a new opportunity for crisis through the creation of feelings of “false confidence”. *The phase of extended family therapy* at the Belgrade School is represented by an essential novelty in the recovery of addicts and their families. The original name, the rehabilitation phase of family therapy, is a somewhat outdated term stemming from the social-medical era, so the newer names were promoted - the reintegration phase; the recovery phase; a rehab/recovery plan, which signifies therapeutic work focused on “residual consequences”. The danger of crisis is manifested in the fact that “protection against therapies system” ceases, as the daily encounter and analysis ends, and the “new life of the dry system” begins in the old environment, which most often has not changed or, possibly, changed only slightly.

The main form of extension treatment is therapeutic groups, colloquially referred to as *family extension groups*. These groups for families on long-term treatment represent the continuity of existence and duration of treatment groups that existed and “worked” in the intensive phase of treatment. Therefore, the created homogeneity of the groups, which function as open groups, usually with the therapist as member of the intensive phase team, is maintained, thus ensuring continuity of working together and closeness to the family and to the elements of the Socioterapy Club. However, there is a solid structure of group work with its confrontational potential in need of the additional clarifications to further deepen insights. An important group-therapy instrument and the pillar is the “rehabilitation and recovery plan”, which provided a family focus on key problems and group structure and homogeneity, but also emphasized the diversity of family problems and goals.

The “rehabilitation and recovery plan” at this stage of family therapy is linked to the process of systematic graduation of the family. Namely, given the line of systematic matriculation of the family at this stage of treatment, participants look at the “unfinished business” in the family life cycle and plan together with the therapist important developmental tasks that they need to perform at a given stage. The timeliness and completeness of these “jobs”, that is, timeliness and unfinished work, must also be tested, as they also indicate not only the state and quality of relationships, but also the processes of transgenerational transmission. The following issues are tested and evaluated: nuclear family boundaries; family rules on environmental relations; functionality and separation of children; the main “themes”, that is, the key value systems that the family fights and advocates for. According to the findings of the one study [6], families which join family alcohol therapy are most often in the middle stages of systemic matriculation, but their “maturity” status is not adequate at that stage³. While working with them, it is necessary to assess the conformity or mismatch of the developmental stage, in which the family should be at the level of its dysfunctionality or “immaturity” in relation to the developmental stage.

Adolescent addiction treatment families are most often at a stage when children need to begin serious independence and separation. The family should be in the stage of full maturity as it turns to the future. Attention is drawn from the selection of thematic options so far, towards the attempt to determine a family identity and a “family place in history”. The assessment of the condition of the family and the degree of conformity-inconsistency with the requirements of a particular stage, also provides opportunities for planning and application of therapeutic interventions that seek to, for example, changes in intergenerational relationships or other changes related to characteristics within family boundaries.

When a family has setbacks and distortions in the middle stages of their development (families with primary school children), the interventions focus on the dynamics of the marital relationship. This primarily means exploring the alcoholics marriage, (but also another type of marital system within the family for treatment) in relation to length of life; breakups; conflicts; emotional distance; communication with children and domination; submissions in reactions; relationships and functioning in systems outside the family; relationships with children; and relationships with primary families.

In doing so, we receive material for therapeutic interventions, because through the quality and manner of emotional relationship in marriage (any dependency involved) – we can inform about the quality of relationships with close and significant persons from the primary family and with the quality of emotional and transgenerational process within the primary family, that is, their relationship to their mother, father, and the dynamics of their parent’s marriage. In doing so, we gain a deeper understanding of the inner dynamics of the individuals they bring into their marital relationship. Since the genogram preceded this “job”, the type of psychological defence mechanisms that partners predominantly use (projection, projective identification, splitting, less often suppression) must now be accurately recognized. The effects of these defences will not be found only in the relations of partners, but also in the relations with children – in various forms of interaction (coalitions, conflicts, distancing); in unresolved fusions in the primary family; and in unresolved relationships with the father, mother or other significant person from the family’s past.

Essentially, at this stage, patient recovery and family progression occur through the use of multiple family group therapy, with the possibility of applying family therapy in a narrower sense, and through a much lower frequency of meetings, as sessions with family or family group meetings take place only once a week. However, at this stage, the processes of significantly greater therapeutic depth are most often taking place, and it involves taking on different modalities of family therapy in addition to the ordinary life and functioning in one’s social and professional environment. Extension groups are led by educated therapists (psychiatrists, psychologists, social workers, special educators) who participate in intensive-day, day-hospital therapy groups. This provides 5-8 “extension groups” for one working week.

Thus, formed and conceptualized therapeutic groups of multiple families can function as homogeneous therapeutic groups with strictly defined program duration. One family’s treatment is formally contracted and can last 1 or 2 years after which the treatment ends with a summary of the treatment that may have elements of the ceremony for success, but also the elements of separation. Then the family or couple leaves the group or can join the already existing Socioterapy Club. Often a whole group of multiple families can spontaneously transform into a newly formed family club. After termination of work in the therapy group of multiple families, it is possible to continue working with the family through occasional conjoint sessions. These “follow-up” sessions should therefore be reconceptualised as integral steps in the process of active termination of treatment, which should be extended to additional several months. In this sense, the Belgrade School’s view is that the already

established links with the family therapist and the family institution should remain a readily available resource that can be reused to solve emerging problems. Since 2001, when the Clinic for Addiction Diseases was established, training in Family Therapy for Addiction Diseases began for 4 semesters, attended by professional workers from IMH and other institutions in Serbia.

FINAL CONSIDERATIONS AND FUTURE PERSPECTIVES

The roots of systemic group family alcohol therapy from which the Belgrade School originated can be recognized in the social-psychiatric paradigm (medical model of addiction, psychodynamic orientation and socialization of psychiatry), which represented the basis for the foundation of the Institute for Mental Health in 1963. Not long after the Sociotherapy Club of Alcoholics have been formed. Elements of this paradigm when it comes to the treatment of alcoholism were realized in the work of the so-called A-section of the Institute's Day Hospital (therapeutic community, group psychotherapy, socio-therapeutic club), which is closest to the so-called Minnesota model. The involvement of the wife and other family members, and later of the professional setting in treatment began in the late 1970s when the Day Hospital for Family Alcohol Therapy was formed in 1978. A general system theory was introduced very consistently into the therapeutic model, which included emphasizing the psychoeducation of the identified patient and family members and the formation of therapeutic group families of multiple families as a form of extended treatment (stabilization phase). With that, the preservation of the concept of the therapeutic community and socio-therapeutic clubs as a form of extended treatment or recovery has been made possible – according to the terminology encountered in recent professional literature.

The application of system theory to addictology, and somewhat earlier to psychology and psychiatry, shed light, first and foremost, on the psychological aspects of human interactions, notably the interactions in the family. The systematic understanding of family interactions inaugurated the revolutionary concept of identified patient, therefore, a different paradigm of symptom creation, in which the identified patient (IP) is the only carrier of the symptom.

Beyond the concept of IP, an important, almost revolutionary paradigm is the circularity in understanding causality (rather than linear determinism). Members of the treatment system and at the same time the behaviour of these individuals are influenced by each other reflection in their process of interaction. This implies the importance of understanding the meaning of family interactions and understanding the nature of the existence or non-existence of the present interactive systemic processes (homeostasis, morphogenesis, adaptation processes).

The basis of the family-system therapy concept of the “Belgrade School of Addictology” is related to understanding the process of systemic equilibrium, through the processes of morphogenesis and homeostasis, namely through the understanding of pathological aspects of homeostasis called “processes of adjustment of the alcoholic family or system”. When the creation of an addiction disease in an individual is considered through the medical model, it is emphasized that addiction develops as a continuum that has quite predictable stages and symptoms, and even outcomes.

However, looking at the development of addiction using the system model, – within the family system, this continuum receives the characteristics of a specific and very diverse process. Namely, alcoholism and other addictions should not last as long and their consequences would be larger and harder as time goes by. It also could not be tolerated and accepted for so long – that, in parallel with the adaptation of the addict's organism and psychological processes in the addict, similar adaptation processes do not take place in the family and environment of the addict. These processes are, by their nature, psychological or,

more precisely, primarily emotional and in their form they are communicative i.e., interactional. In their essence they are circular, because they belong to the domain of mutual relations and communication among the family members to whom the addict belongs all the time and in which he/she exists together with everyone else and with his/her alcoholism. In sum, these are the mutual relations of the individual addict with the individual family members, with the family as a whole and with the family environment as an ecosystem.

Addictions (as well as other psychiatric and social phenomena) are therefore not understood as disorders that define or condition only the characteristics of personality and events in an individual, but are quite clearly defined (and manifested) as a disorder of interactions in the system and as conditions for the process to take place over time (maternal life cycle). Maintenance of this disorder is possible due to pathological stability or homeostasis of the system ("adjustment processes"). Addiction appears as stress and as a process that organizes the family. That way the conditions for the addiction containment and functionality of the addict inside the very system are made possible. With it, the system itself is sustained by the environment but at the cost of its pathologic stability, future dysfunctionality through the process of entropy [1, 8], which condition the non-acceptance of treatment or late start of treatment so that the recovery can be made more difficult (as the family reconstruction is not possible).

Stopping the flow in this continuous process of development is only possible by stopping the process of adaptation. The extent to which an individual or family will arrive in that continuum depends on the characteristics of the self-process or on the characteristics of the system. Some elements of these processes are in the addict, but many are outside the addict-individual, so all elements are in the system.

The key systematic attitude of the "Belgrade School of Addictology" is that each family has its own specific addiction. In other words, the processes of creating each addiction cannot be torn from the totality of family interactions and considered as a separate "whirlwind" around a dependent individual or as a special "mysterious" (neurobiochemical) process in an individual, which can only arise from excessive substance use. Every systematic interaction process can be clearly found in current events in the family and social environment. Therefore, the whole should be observed, because the processes of reciprocity are at stake and can be understood through an understanding of the whole, rather than by analysing the states and characteristics of individuals.

So, it is only from understanding the whole that we can also understand how some traits have arisen and how disturbed relationships are currently maintained; how addiction intensifies; and finally how it is passed on to individual members in the next generation (some of it are not passed at all). So, all the members of the system participate in these processes all the time.

At the end of the 20th century and with the beginning of the process of globalization, as well as the political and economic transition in region, there is an increasing number of alcohol addicts, but also an increasing number of young people addicted on other psychoactive substances (cannabis, heroin, stimulants), and so-called non-chemical addicts (pathological gambling, video games, internet addictions). At the Institute of Mental Health, the application of systemic group family therapy of all addictions is continuing, now in the newly formed Clinic for Addiction Diseases in the clinical ward and in three day hospitals. Due to the heterogeneity of the population of new addicts and the disappearance of the welfare state, systemic group family therapy is applied in a modern format with much more application of eco-system elements and with attempts to integrate ecosystem and family-system elements. It is obvious that one can speak of the Belgrade School of Addictology as a theoretical and therapeutic uniqueness.

Instead of a conclusion, I would like to emphasise clearly the fact that the history of the development of therapeutic concepts in the treatment of addiction diseases in Belgrade and Serbia, indicates the obvious existence of a process in which changes took place. Namely, therapeutic concepts are inevitably marked by eco-systemic events in times and places where we live and work. Eco-systemic processes significantly determine the characteristics of individuals, families, social institutions, but also the characteristics of health and specification of the disease, including diseases of addiction and therefore, almost passively, the transformation of therapeutic models that obviously cannot be purely medical or purely psychiatric is made. Addictology should continue to be integrative, based on existing concepts that have preserved the sustainability and vitality of the “School” with the use of novelties and necessary transformations, which have emerged from the peculiarities of the population of new addictions, so the Belgrade School of Addictology should remain and be at its core eco-systematic, live process; counteracting with it the interactions as it is exposed due to the increasing homeostatic events through which the “old” and “new” addictions are produced.

REMARKS

¹In the late 1950s, major changes in the field of psychiatry occurred in the world. Society's calls for more humane treatment of psychiatric patients and their inclusion in the community, as well as new breakthroughs in pharmacotherapy, have led to fundamental changes in the understanding of psychiatry and psychiatric care to date. Led by these changes, a group of Serbian psychiatrists conceived and formed the Institute for Mental Health, which in 14th April 1963 officially opened. The first psychiatric institution in this part of Europe with a complete socio-psychiatric orientation began to operate, placing the focus of care and support on patients in the community and insisting on social and psychological methods of treating psychiatric illness. Then, the daily hospitals were introduced as a semi-hospital type of psychiatric treatment, as well as numerous psychotherapy and group therapy methods in treatment (by developing a democratic therapeutic milieu through the organization of therapeutic communities of staff and patients, [https://imh.org.rs › about -institute](https://imh.org.rs/about-institute) › history).

²The description of a key point in systemic family therapy of addictions with the name “large representation” is given through an example of the treatment of alcoholism, or through the description of a “large representation” of a spouse from an alcoholic marriage. The principles of performing this therapeutic intervention are the same for other types of addictions and for other types of addictive families (adolescent addictions, women's addictions, divorced addicts, pathological gambling, internet addiction).

³In the systemic matriculation of the family, the middle stage is the stage of consolidation during which the choice of “themes and opportunities” of the family is made. At that stage, the family is highly reactive, but significantly conditioned by the type of relationships that are established in the family among its members and above all in the marital subsystem. In one family, spouses can form egalitarian relationships, so the parallel course of their individual development will positively evolve. In the other family, the primacy of spousal behaviour within parental functioning may influence the appearance of the child or children as major family themes – goals. (e.g. fatigue, parental projection).

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